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Sebelius vows to boost pre-existing conditions program

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A slow-starting insurance program for people with pre-existing conditions who have struggled to find health insurance has more than doubled in size since February but still lags far below early estimates. HHS Secretary Kathleen Sebelius told members of the House Energy and Commerce Committee that more than 18,000 have enrolled in the Pre-Existing Condition Insurance Plan created by the Patient Protection and Affordable Care Act. That remains far below the 200,000 people HHS officials previously said it was expected to include at any one time.

Sebelius promised additional efforts to grow the program more quickly.

"For many, these plans provide access to life-saving treatment, so it is vital that we continue to find those eligible and get them enrolled," Sebelius said.

The **$5 billion program**, launched in July 2010, aims to provide bridge coverage until state insurance exchanges are established in January 2014.

Many people who have wanted to enroll in the plans could not afford the premiums, according to an HHS official. So the department is trying to get the private insurers and states that offer the plans to lower those premiums. The federal government has contracted with the Government Employees Health Association—a private insurer—to provide coverage in 23 states and the District of Columbia, while 27 other states run their own pre-existing condition insurance programs.

STATE HEALTH POLICY

Briefing

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What a Difference a Dollar Makes: Affordability Lessons from Children's Coverage Programs that can Inform State Policymaking under the Affordable Care Act

BY LEIGHA O. BASINI

STATE HEALTH POLICY BRIEFING PROVIDES AN OVERVIEW AND ANALYSIS OF EMERGING ISSUES AND DEVELOPMENTS IN STATE HEALTH POLICY.

States are responsible for on the ground implementation of the Patient Protection and Affordable Care Act, including expanding coverage options through Exchanges and other health insurance programs. This *State Health Policy Briefing* examines the affordability of coverage options that will become available as states implement the Patient Protection and Affordable Care Act. It also draws on lessons learned from the successful Children's Health Insurance Program, which can serve as a model for states as they seek to promote the affordability of coverage for their residents. To promote the affordability of coverage, states may focus on:

- Staying flexible and monitoring the impact of cost sharing policies;
- Tailoring cost sharing;
- Aligning affordability across programs and coverage types;
- Providing a consumer-friendly experience; and
- Examining alternatives to premium increases as a way to reduce program costs.

NATIONAL ACADEMY *for* STATE HEALTH POLICY

The Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act (together, ACA) will provide coverage opportunities for many more adults and children. Some ways in which people will obtain coverage include expanded Medicaid programs, the state Children's Health Insurance Program (CHIP), employer-sponsored insurance (ESI), and newly created subsidized and unsubsidized coverage through Exchanges. State and federal laws, including ACA, set forth affordability standards for different coverage types. States have varying degrees of flexibility in implementing coverage provisions under ACA so that programs can be tailored to states' unique needs. Where such flexibility exists, states have pivotal decisions to make to ensure that coverage is truly affordable for as many people as possible.

This issue brief examines the concept of affordability, standards for measuring it, and how affordability is inextricably tied to access to care. It also considers the affordability of current coverage options and reviews the many affordability provisions in ACA. Finally, it explores lessons that state policymakers can learn from state CHIP programs.

What is Affordability and Why is it Important?

Precisely what coverage is affordable and how to determine affordability have been the subject of much debate. Discussions on affordability surfaced in 2006 as Massachusetts enacted and subsequently implemented large-scale health care reform. Last year, these discussions continued when the U.S. Congress considered various health care reform bills, including those by the Senate Finance Committee; Senate Health, Education, Labor and Pensions Committee; and House Tri-Committee, all of which provided sliding insurance premium subsidies based on income, but at different levels. And even before these discussions, legislators and program administrators have long worked to address affordability in the context of Medicaid, CHIP, and other programs.

The affordability discussion has continued with enactment of federal health care reform, particularly considering ACA's individual mandate, which requires most Americans to obtain health insurance or face a monetary penalty.[1] Especially given that the law contains an individual mandate, fairness dictates that coverage be affordable. There are various cost protections in ACA and other federal and state laws designed to ensure affordability of coverage. This is central to successful ACA implementation, as 89 percent of currently uninsured Americans will qualify for free or reduced-cost coverage under ACA.[2]

More than one school of thought exists regarding affordability standards, particularly with regard to private coverage. One such standard, the Family Economic Self-Sufficiency Standard, considers what families need to earn in order to afford necessary items such as food, clothing, shelter, childcare, health care, and miscellaneous expenses.[3] One notable flaw with this standard is that families often underreport actual earnings, for example by not reporting under the table income; thus, the overall picture of household finances may be somewhat inaccurate.[4] A second affordability standard considers the amount that people who are insured actually spend, rather than plan to spend, for their coverage.[5] This considers actual spending as evidence of the point at which people purchase coverage and obtain care and the threshold at which they deem premiums and cost sharing too costly and forego them.[6] Regardless of the standard used, affordability will continue to be important to all children and families.

Affordability in Current Children's Coverage Options

Current coverage options available to children include Medicaid and CHIP, which are free or low-cost; Medicaid and CHIP buy-in and premium assistance programs in states where they are available; private ESI in which an employer may contribute towards the cost of premiums, though usually at lesser amounts for dependents; and coverage purchased on the individual market, where the family is responsible for the entire premium. States aiming to provide affordable coverage may want to focus on minimizing cliffs and gaps across different programs. States can look to their CHIP programs when considering how to provide affordable coverage under ACA.

Medicaid

Cost sharing for Medicaid enrollees has been historically very low, if states imposed requirements on enrollees at all. Prior to the Deficit Reduction Act of 2005 (DRA), states could not charge premiums or fees for categorically needy children — children who by and large account for most children in the Medicaid program — to enroll or participate in Medicaid. Though "nominal" copayments permitted under Medicaid ranged from $0.50 to $3.00, cost sharing did not apply to children's coverage.[7]

The DRA, which was designed to reduce federal entitlements, made several changes to Medicaid.[8] Under the DRA, states may charge premiums for certain populations, including children with family incomes above 150 percent of the Federal Poverty Level (FPL) whose coverage is not mandatory. Even post-DRA, premiums are not allowed for children in families at or below 150 percent of the FPL.[9] The DRA also authorized states to impose cost sharing requirements on certain services for all children.[10] For example, families over 150 percent of the FPL could be required to pay up to 20 percent of the cost of outpatient care, families between 100 and 150 percent of the FPL could pay up to 10 percent of such cost, and families at any income level could incur cost sharing for certain prescription drugs.[11] The DRA caps out-of-pocket spending at 5 percent of income for Medicaid

enrollees who are not exempt from this provision and also prohibits cost sharing for preventive care.[12]

Enrollees whose income hovers just above the poverty level are highly cost-sensitive. While premiums and cost sharing may seem minimal, particularly when compared to private insurance, slight cost increases can have a dramatic impact on access to care for economically vulnerable families. When formerly free coverage instead costs one percent of income, an estimated 16 percent decrease in enrollment would result; when formerly free coverage is 5 percent of income, enrollment decreases 74 percent.[13] In 2003, Oregon increased its Medicaid premiums for adults, and nearly 50 percent of the enrollees lost coverage. Of those who lost coverage, two thirds became uninsured.[14]

Further, although minor cost sharing increases often seem to be an appealing way for states to spend less money, such increases may actually cost states more. As people are unable to afford cost sharing and forego care, they often become sicker and eventually visit costly sites such as emergency rooms, which increases the state's costs. Additionally, in Oregon, although increased premiums had the potential to bring the state additional money, the amount the state received in premiums actually decreased due to lowered enrollment.[15]

CHIP

CHIP provides coverage to children who are not Medicaid-eligible and lack access to affordable private coverage. Income eligibility limits and program rules must adhere to federal laws and regulations, though states have significant flexibility in program design. This flexibility makes the program a fertile ground for experimentation with program structure and oversight, income eligibility limits, delivery of care, and cost sharing. Many states' premiums are on a sliding scale, particularly in states that have more generous income thresholds, so that people with higher incomes contribute more than those with lower income. Presently, income eligibility maximums range from 160 percent of the FPL in North Dakota[16] to 400 percent of the FPL in New York, with most states falling between 200 and 250 percent.[17]

Like the limit for Medicaid added with the DRA, federal CHIP rules have always limited cost sharing up to an aggregate spending cap of 5 percent of total income.[18] However, it is rare that a family actually meets the 5 percent, which some states have lowered. For instance, in Texas, families with income at or below 150 percent of the FPL pay no more than 1.25 percent of income towards coverage, and this amount increases to 2.5 percent for families with income between 151 percent and 200 percent of the FPL.[19] As of 2008, 32 states charged premiums to at least some CHIP enrollees.[20] The highest premium was $98.00 per month.

CHIP benefit packages also have a very high actuarial value. According to a recent study of 17 states, the median actuarial value of CHIP plans ranges from 98 to 100 percent, meaning that families in these states pay, on average, up to 2 percent out of pocket.[21] One reason CHIP has a high actuarial value is because the program does not permit cost sharing for well-baby or well-child care, including services such as routine physical examinations and childhood immunizations.[22] Generally speaking, deductibles cannot exceed $3.00 per family per month, and copayments cannot exceed $5.00.[23] States may also opt to permit cost sharing for non-emergency use of the emergency room, in limited circumstances.[24]

Affordability examples in CHIP programs

For CHIP-eligible families, a difference of a few dollars in premiums or cost sharing has a noticeable effect. In fact, a recent analysis concluded that among families with children in Medicaid and CHIP, even families that do not have any cost sharing endure financial hardship due to other financial pressures.[25] As with Medicaid, several states have seen even modest premium increases result in disenrollment.[26]

Kentucky's CHIP program began charging families with incomes between 151 and 200 percent of the FPL premiums of $20.00 per month in November of 2003. Approximately 700 children lost coverage due to failure to pay premiums in the required time. Most of these children reenrolled, costing the state to process the new applications. Kentucky also spent about $500,000 each year to produce and mail invoices. The state lost federal matching funds, as states are not eligible for a federal match on any money paid by enrollees instead of the state. Ultimately, by imposing premiums on families in this income range, the state estimates a loss of approximately $100,000 a year. Thus, in 2010, Kentucky suspended its premium requirement through a state budget bill.[27] Unfortunately, because the premium requirement is in statute, the premiums have been

suspended rather than eliminated, and legislation is needed to permanently eliminate the premiums.

New Jersey had a similar experience when the state eliminated premiums for children up to 200 percent of the FPL in 2009. The state decided to eliminate premiums after reviewing the cost of reenrolling children whose coverage terminated due to failure to pay the premium. Like Kentucky, New Jersey determined that it was not a cost-effective use of funds or time to disenroll children for failure to pay the premium on time and then reenroll them shortly thereafter. As soon as New Jersey eliminated premiums, enrollment started to climb. Between June 2008, when the state charged premiums, and June 2009 when it stopped charging premiums, enrollment grew from 33,203 to 36,525. By June of 2010, enrollment was 45,765.[28]

CHIP buy-in programs

CHIP buy-in programs, in which families with incomes that exceed CHIP eligibility thresholds purchase CHIP coverage without any subsidization, are another coverage option in more than a dozen states where such optional programs exist.[29] In most of these states, families at any income level may purchase the unsubsidized coverage. Although buy-in premiums are generally lower than private coverage and coverage on the individual market in particular, they are not subsidized and often exceed 5 percent of income.[30] Full CHIP premiums are frequently several times their subsidized counterparts. Because buy-in premiums in most states do not vary based on income, premiums as a percent of income are highest for families with incomes just over CHIP income thresholds. Consequently, families losing eligibility for subsidized CHIP coverage that wish to purchase buy-in coverage may face steep cliffs, even though their income only slightly surpasses CHIP limits. Similar disparities exist for families with multiple children, as buy-in programs frequently do not offer cost savings for them.

Overall, take-up remains relatively low for states implementing buy-in programs for children whose families earn too much money for Medicaid or CHIP coverage but cannot afford or access private coverage.[31] One probable explanation for this is that families at this income level are very price-sensitive and cannot afford paying the full premium.[32] Though buy-in premiums may be unaffordable for many families with uninsured children, these programs remain an attractive option for families that find premiums affordable, do not have access to private insurance, or have children with special health care needs and have no other coverage options.

Commerical Insurance

Commercial insurance is considered the costliest coverage option, though premiums vary widely based on many factors. Some primary reasons for premium variance include:

- The benefits covered;
- Cost sharing required;
- Whether the coverage is purchased in the individual, large group, or small group market;
- The scope of the provider network, if applicable;
- The extent to which the state regulating the coverage uses mechanisms such as medical loss ratio requirements, risk adjustment, and prior approval of premium rates to control costs; and
- Rating factors such as age, gender, and health status, which insurers use to set premiums in most states.

For example, point of service coverage, which provides out-of-network coverage but at greater cost sharing than for in-network coverage, for one adult and children purchased in Florida's individual market is as low as $138.00 per month but comes with a $10,000 annual deductible and 20 percent coinsurance.[33] In New York's individual market, point of service coverage for one adult and children with the same insurer costs $3,597 per month but has no deductible and low copayments.[34]

For those with ESI, employers and employees normally share in premium payment. In 2010, the average monthly premiums for ESI were $420.75 per month for individual coverage and $1,147.50 per month for family coverage.[35] Employees in 2010 contributed an average of nineteen percent of premiums for individual coverage and thirty percent for family coverage.[36] Consequently, it can be extrapolated that the average individual with employer-sponsored family coverage spends a considerable percentage of income on premiums alone, which does not take into account additional spending as a result of cost sharing requirements.

Cost sharing, which includes deductibles, copayments, and coinsurance, also varies depending on the plan selected. On average, these amounts are notably higher than cost sharing in Medicaid and CHIP. In 2010, the average family deductible for HMO coverage was $1,321.00, though 96 percent of people could obtain preventive care before meeting the deductible.[37] The average copayment for a primary care office visit was $21.00. [38]

Like CHIP buy-in programs, commercial insurance is not available to all children. Regardless of affordability, many states do not sell child-only coverage, and some employers do not offer ESI or offer it only to employees and not to their dependents. Affordability is important regardless of coverage type and will continue to be so as states implement the Affordable Care Act.

Affordability in the Context of ACA

Policymakers most often examine health insurance affordability, whether in public or private coverage, as a percentage of income spent towards premiums and cost sharing. The health care reform bills proposed in 2009 contained limits on the amounts people would be required to spend towards premiums and cost sharing, depending on income. As examples of what may be considered affordable, under the Senate bill (H.R. 3590), people from 300 to 400 percent of the FPL would pay up to 9.8 percent of income, but under the Senate Finance Committee bill (S. 1796), the maximum was 12 percent. Conversely, for lower-income people, the Senate Finance Committee bill was more generous, with people up to 134 percent of the FPL paying up to 3.7 percent of income, while under the Senate bill, they would pay up to 4 percent.[39] Both of these bills and the House bill (H.R. 3962) permitted people at 200 percent of the FPL to pay more than 5 percent of income towards coverage.

Premiums and Cost Sharing in ACA

ACA did not change existing law regarding affordability for Medicaid and CHIP enrollees, though it will expand Medicaid eligibility to 133 percent of the FPL in 2014. For people who are not Medicaid-eligible, the law creates affordable coverage options through premium and cost sharing subsidies.

Exchange coverage – premium and cost sharing credits

Premium subsidies

Under ACA, most people, including children, will be required to have heath insurance. ACA includes provisions that give cost sharing credits and refundable premium tax credits to people with incomes up to 400 percent of the FPL who are ineligible for Medicaid and CHIP.[40] The maximum percentage of income that a person will have to pay for premiums depends on household income (see Table 1). The premium tax credits are advanceable, so that recipients immediately receive the credit and do not have to pay the unsubsidized premium amount and seek reimbursement later when filing taxes. However, recipients will need to annually reconcile the tax credit received with their actual income and repay any excess credit, up to a limit.[41]

Table 1: Premiums as a Percent of Income under ACA

Household Income as a Percent of the FPL	Premium Range as a Percent of Income
Up to 133%	2%
133-150%	3-4%
150-200%	4-6.3%
200-250%	6.3-8.05%
250-300%	8.05-9.5%
300-400%	9.5%

The law sets forth different levels of coverage that people can purchase — platinum, gold, silver, and bronze. Although those eligible for credits may purchase any level of coverage, credits are tied to the second lowest cost silver plan, which has a 70 percent actuarial value.[42] In this context, actuarial value is the average percentage of anticipated costs that an insurer will pay towards care for people insured in a given product.

Low-income people are not the only ones who will benefit from Exchange subsidies. Employees who are offered ESI but who must contribute more than 9.5 percent of household income towards coverage or who are offered ESI that has an actuarial value less than 60 percent may also obtain subsidized Exchange coverage.[43]

Additionally, ACA includes a handful of exemptions from the individual mandate, including one due to lack of

affordability.[44] If a person is required to contribute more than 8 percent of income towards coverage for the month, then the person may receive an exemption.

Cost sharing subsidies

ACA also provides reduced cost sharing for people up to 250 percent of the FPL.[45] The cost sharing assistance provides significant help. Without this assistance, the actuarial value of silver coverage, to which premium tax credits are tied, would be 70 percent for all people — meaning people on average would otherwise pay up to 30 percent of costs out-of-pocket. The subsidies increase the actuarial value of coverage (see Table 2).

TABLE 2: ACTUARIAL VALUE OF EXCHANGE COVERAGE WITH COST SHARING AND PREMIUM ASSISTANCE SUBSIDIES

Household Income as a Percent of the FPL	Actuarial Value of Coverage
100-150%	94%
150-200%	87%
200-250%	73%
250-400%	70%

While cost sharing subsidies in the Exchange are beneficial, the difference in relation to CHIP cost sharing is striking. A recent study of 17 states found that the median actuarial value of CHIP coverage for families up to 225 percent of the FPL is a robust 98 percent or more.[46] Yet if a family loses CHIP coverage, even subsidized Exchange coverage with cost sharing assistance can be considerably more costly. For example, in Nevada, CHIP coverage at 175 percent of the FPL has a 100 percent actuarial value.[47] At 201 percent of the FPL, Nevada children would likely go to the Exchange for coverage, where the actuarial value would be 73 percent. Such a dramatic drop in actuarial value produces a cliff for enrollees in terms of actual coverage.

Basic Health

States have the option of offering a Basic Health program for people up to 200 percent of the FPL who are not Medicaid-eligible.[48] States that choose to create Basic Health programs and meet federal requirements will receive 95 percent of the funding that the federal government otherwise would have provided to enrollees through premium subsidies and cost sharing credits. Basic Health premiums cannot exceed those of the second lowest cost silver plan. Cost sharing cannot exceed that of platinum

OTHER ACA PROVISIONS AFFECTING AFFORDABILITY

In addition to premium and cost sharing subsidies, ACA includes some other provisions regarding affordability.

- ACA prohibits cost sharing for preventive care for plan years starting on or after September 23, 2010.[1] (This includes commercial group and individual health coverage and will include Exchange coverage, but it does not apply to grandfathered plans.[2])
- The law limits out-of-pocket spending for Exchange and employer coverage. The annual out-of-pocket maximum is the same as that for high deductible health plans.[3] In 2011, the maximum for high deductible plans is $5,950 for individual coverage and $11,900 for any other coverage, so amounts for Exchange coverage will likely be slightly higher in 2014, as the figures are indexed to inflation. (This does not apply to self-funded or grandfathered coverage.)
- ACA limits deductibles for small group employer coverage to $2,000 per year for individual coverage and $4,000 per year for all other coverage. Enrollees may access preventive care before meeting the deductible.

1 ACA §1001, 124 Stat. 131 (2010).

2 Grandfathered plans are plans that were in existence before ACA that are allowed to remain in the marketplace. Grandfathering refers to the ability of the plans to remain largely intact as they were prior to ACA. Generally speaking, grandfathered plans are exempt from many of the new consumer protections and other requirements in ACA. Plans that commenced after ACA's enactment, on the other hand, are not grandfathered and therefore not exempt. Along the same lines, plans that were in existence before ACA but have been substantially modified since ACA's enactment will lose grandfathered status.

3 ACA §1302(c)(1), 124 Stat. 165 (2010).

coverage for people up to and including 150 percent of the FPL and cannot exceed that of a gold plan for those over 150 percent. Enrollee costs are after the deduction of any tax credits. Basic Health plans will permit eligible family members to all be covered under the same plan.

Lessons Learned from Children's Coverage

Although defining affordability is challenging, the importance of affordability in access to care is largely uncontroverted. In addition to setting forth affordability standards, ACA acknowledges the significance of affordability by requiring the Government Accountability Office to conduct a report on the affordability of coverage.[49] Further, the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) created the Medicaid and CHIP Payment and Access Commission (MACPAC), which is charged with reviewing payment policies and the relationship between the policies, access, and quality.[50] However, what is affordable coverage is nuanced and, in addition to cost alone, is dependent on state policies and family circumstances. Studies show that low-income families are very price-sensitive and that even small increases can lead to dropped coverage or foregone care. States will want to consider how to make coverage affordable and accessible when implementing ACA and should consider lessons learned from state CHIP programs and children's coverage when designing coverage under ACA.

Stay Flexible and Monitor the Impact of Cost Sharing Policies

ACA's affordability provisions set forth minimum requirements for Exchange coverage. In light of ACA, states will need to examine and possibly revise existing state law pertaining to affordability in the commercial market and consider careful implementation of any new state laws to dovetail with ACA's requirements. Yet, states may want to avoid confining themselves to detailed affordability standards in legislation. As times change, states may see the need to change cost sharing requirements or other policies. Legislation should contain a strong framework and set forth basic affordability protections. However, states may wish to consider giving their agencies regulatory authority to examine and modify any state affordability standards.

The experience of Kentucky's CHIP program, as previously noted, is a prime example of how one state creatively solved a problem that was detrimental to both the state and enrollees when its legislation produced undesirable results. The imposition of premiums for families at certain income levels caused children to lose coverage and also caused the state to lose, rather than save, money. Although the premiums were set in statute, the state used a budget bill to to suspend them.

Monitoring enrollment and retention against changes in premiums and cost sharing is essential. If states are not achieving desired results, they may want to look at cost sharing levels and make enrollment and utilization projections based on varying enrollee requirements. States may also want to consider tracking enrollee cost increases against enrollment to avoid the disenrollment as seen in Kentucky and New Jersey when premiums increased.

Consider Alternatives to and Ramifications of Premium Increases

In times when states are struggling financially and state policymakers are looking for ways to trim spending and generate revenue, increasing premiums may seem like an attractive and easy solution, particularly in programs where maintenance of effort requirements do not apply.[51] However, as states consider these options, they will likely need to consider the longer-term impact of increases. As seen in Kentucky, premium increases may inadvertently have two unwanted effects: increased state cost and decreased enrollment.

States can carefully examine whether premium increases will cause people to lose coverage, either through the inability to afford premiums or failure to pay premiums on time. States may also consider the costs associated with reenrolling people who will likely remain eligible and eventually reenroll. Finally, states that are considering imposing premiums may want to look at the cost of premium billing and any lost federal matching funds when determining if the action would save state money. Some states have passed legislation requiring commercial insurers to meet minimum loss ratio requirements and receive state approval prior to implementing rate increases to provide enhanced oversight over rate increases.

Tailor Cost Sharing to Drive Desired Results

Smart design of premiums and cost-sharing structures can produce positive results. The RAND Health Insurance Experiment showed that with children, cost sharing decreases overall utilization.[52] Even in the face of increased premiums and deductibles, people can often obtain preventive care without paying coinsurance or first meeting a deductible. High deductible health plans frequently permit the insured to receive preventive care before meeting the deductible. Children enrolled in CHIP receive preventive care without cost sharing, and ACA requires most health plans to provide preventive care without cost sharing. States may want to experiment with no or low cost sharing for non-preventive services, such as treatment for diabetes and asthma that can have high costs if left untreated. Conversely, they may also want to impose higher cost sharing for non-emergency use of the emergency room, as some state CHIP programs do, to deter improper utilization.

Align Affordability Across Programs and Coverages

One key test of ACA's success will be how well states integrate affordability across different coverage types so that families do not face steep cliffs when moving from one coverage type to another. Cliffs are most prominent between CHIP eligibility and eligibility for Exchange coverage with subsidies and between Exchange coverage with subsidies and unsubsidized Exchange coverage. Although federal law provides that families must not pay more than 5 percent of income towards premiums and cost sharing in CHIP, the maximum is much smaller in most states. In a state that has a 300 percent of the FPL eligibility threshold for CHIP, a family that loses CHIP eligibility at 301 percent of the FPL could have to pay up to 9.5 percent of income towards subsidized Exchange premiums, which is considerably more than 5 percent or less for CHIP. For example, in Texas, premiums and cost sharing are capped at 2.5 percent of income for families between 151 to 200 percent of the FPL. In the Exchange, Texas families at 201 percent of the FPL will pay up to 6.3 percent of income towards coverage — more than twice what they would pay at 200 percent. States may want to consider ways to minimize these cliffs to avoid unwanted consequences. ACA is explicit in that the law sets minimum subsidization levels for Exchange coverage and states may, at their own expense, provide additional premium and cost-sharing assistance.[53] Although states likely do not have money for additional premium subsidization, they could use the premium rate setting provisions in ACA to minimize excessive rate increases.

States may also want to align copayments and coinsurance across coverage types. For example, preventive care under non-grandfathered plans and preventive care under CHIP do not have copayments. If states reduce or eliminate cost sharing for certain diseases in one program, they should consider mandating similar or equivalent cost sharing for other programs. They may also wish to change copayment requirements for non-grandfathered coverage through state legislation.

Provide a Consumer Friendly Experience

There are several things that states may do to improve the overall consumer experience of paying for health care. Navigating the health care system can be complex and confusing. States may want to look at their processes to ensure that they are user-friendly, as consumer-friendly policies may also decrease disenrollment.

As methods for paying bills now extend beyond mailing a check, many CHIP programs have followed the lead of insurance and other companies and offer enrollees multiple payment options. For instance, some CHIP programs accept credit cards, employee wage withholding, in-person cash payments, and online payments.[54] In 2008, more than 40 percent of CHIP programs that charged premiums accepted five or more methods of payment. States can also send e-mail and text reminders regarding upcoming payments.

Under CHIP, out-of-pocket spending is capped at 5 percent of income. However, the law is currently silent as to who must track spending towards this out-of-pocket maximum. Over one third of states that require cost sharing also require the child's family to track cost sharing.[55] States that do not track cost sharing may want to consider doing so, as it can be unwieldy for families to individually save invoices and calculate this themselves, particularly when different family members have different coverage and out-of-pocket maximums. Similarly, private plans in the Exchange could also track enrollee spending.

CHIPRA requires CHIP programs to provide a thirty-day grace period for premium payment.[56] States should

determine if this grace period corresponds with state insurance law and consider amending the law if necessary so that they are aligned. They may also want to require insurers to send an interim letter to enrollees before the final termination notice. Insurance policies and disclosure statements should also explain grace period terms in readable understandable language. Grace periods are often a source of confusion for consumers; consequently, flexibility in implementing grace periods is key. It is far easier and less costly to give families flexibility when paying premiums or reinstate coverage than to have people drop off coverage, reapply, and consequently reenroll.

Conclusion

Under ACA, states are charged with providing a streamlined, seamless, and consumer-focused experience for families that will obtain coverage through Medicaid, CHIP, ESI, Exchanges, and other coverages. They must also follow the requirements set forth in ACA regarding the affordability of coverage. Although the law provides free and reduced-cost coverage to eligible individuals and families, this does not automatically mean that all people will have access to affordable coverage. As families' composition and income changes, so will their options and costs. State policymakers should examine and build on the lessons learned from state children's coverage programs when looking to the future and designing affordable coverage options under ACA.

Endnotes

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GOP lawmakers introduce bills targeting Medicaid maintenance-of-effort requirements

By **Jessica Zigmond**
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Tags: American Recovery and Reinvestment Act, Associations, Hospitals, Legislation, Medicaid

Republican lawmakers on Tuesday introduced bicameral legislation to repeal Medicaid maintenance-of-effort requirements they say are burdensome and force states to make significant cuts to programs such as education and law enforcement.

Sen. Orrin Hatch (R-Utah) introduced the State Flexibility Act, while Rep. Phil Gingrey (R-Ga.), a physician, and Rep. Cathy McMorris Rodgers (R-Wash.) co-sponsored a companion bill in the House.

The maintenance-of-effort requirements for Medicaid were first included in the American Recovery and Reinvestment Act of 2009 and then expanded last year in the Patient Protection and Affordable Care Act. Under this provision, states can receive increased funding for Medicaid if they agree not to reduce eligibility requirements below their February 2009 levels. But Republicans in both chambers of Congress argue that the requirements are onerous to states, which are demanding more flexibility to manage their programs.

In Pennsylvania, Medicaid now accounts for 31% of the state's budget, and that could grow to as high as 60% by decade's end due to the expansion outlined in the Affordable Care Act, Rep. Joe Pitts (R-Pa.), chairman of the House Energy and Commerce Health Subcommittee, said at a news conference in the Capitol Tuesday. And because increased federal funding won't cover the entire expansion, Pennsylvania will need to find an additional $2 billion to cover expenses. He said that equals the combined funding of more than a dozen of the state's departments—including agriculture, community and economic development, and the judiciary and legislative branches of government.

As a result, Pitts said, basic government functions will be affected. "Our legislation will grant at least some level of flexibility for state governments. We want states to be able to provide this critical service, and state legislators want to run good programs that improve the quality of life for their constituents," he added. "And we should remember that Washington doesn't always know best."

Meanwhile, Sen. Mike Johanns (R-Neb.), a former governor, said the legislation will provide governors with more flexibility to manage their budgets. He also portended what could happen if such action isn't taken.

"Having been down this road so many times before, I can tell you what happens. Providers are cut," Johanns said at the same news conference. "Year after year after year, these are doctors and hospitals that are already providing medical care below the cost of that care. And so they are already going broke trying to provide Medicaid services. It's not accidental that 40% of our doctors across the country don't take Medicaid patients."

In early March, **several healthcare associations** sent HHS Secretary Kathleen Sebelius a letter saying they opposed repealing maintenance-of-effort requirements because, they said, doing so would transfer many low-income Americans off Medicaid and raise the number of uninsured—as well as increase the burden on providers.

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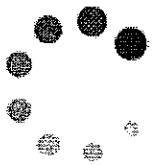

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